

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4965 CERTIFICATE OF DEATH

0405166
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 3Mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month April Day 28 Year 1956		4. DATE OF DEATH Month April Day 28 Year 1956	
3. NAME OF DECEASED (Type or print) Jennie Louise Allen	First Jennie Middle Louise Last Allen	4. DATE OF DEATH Month April Day 28 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1861
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William McCormick		14. MOTHER'S MAIDEN NAME Jane Rowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James Allen		Address Pittsburgh, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 1 hour Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6, 1953 to April 28, 1956 , that I last saw the deceased alive on April 28, 1956 , and that death occurred at P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Feaster, Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 58 2nd St. Oakland, Md. 5-2-56	
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/1/56	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.		ADDRESS Cumberland, Md	
24a. REC'D BY REGISTRAR 4/30/56		24b. REGISTRAR'S SIGNATURE Julius Rowan	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

166

BUREAU V. 2

MAY 7 1952

RECEIVED
4/21/52

CERTIFICATE OF DEATH

Reg. Dist. No.

4066

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First WALTER LEONARD Middle BURKHARD Last BURKHARD		4. DATE OF DEATH Month April Day 14 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1893
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm	
11. BIRTHPLACE (State or foreign country) Accident, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Burkhard		14. MOTHER'S MAIDEN NAME Mary Zinken	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs Artie Burkhard, Accident, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency (c) Arteriosclerotic heart disease			
INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 years 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute diaphragmatic pleurisy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26, 1955 to April 14, 1956 , that I last saw the deceased alive on April 12, 1956 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Paige Strong M.D.		ADDRESS (Street, city or town, state) Salisbury, Penna DATE SIGNED April 14, 56	
PHYSICIAN'S NAME (Type) A. PAIGE STRONG		SAILABURY, PA.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/56	
22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran		22d. LOCATION (City, town, or county) (State) Accident, Garrett Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman		ADDRESS Grantsville, Md.	
24a. REC'D BY REGISTRAR APR 18 1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4967
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. VA. b. COUNTY 85X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b APP. 14 HRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS AURORA			
3. NAME OF DECEASED (Type or print) First PATRICK Middle HENRY Last DOUGHERTY				4. DATE OF DEATH Month APRIL Day 13 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 6, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY SALESMAN		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. FRANCIS DOUGHERTY AURORA, WEST VA. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure + fibrillation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Art. C. V. D. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-12 , 19 56 , to 4/13 , 19 56 , that I last saw the deceased alive on 4/13/56 , 19 56 , and that death occurred at 10:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas J. Lusk M.D.				ADDRESS (Street, city or town, state) Oakland, MD DATE SIGNED 4/13/56			
PHYSICIAN'S NAME (Type) THOMAS F. LUSBY M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/16/56		22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Oakland MD	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Spiegler		ADDRESS Doris W. Co.		24a. REC'D BY REGISTRAR 4/14/56		24b. REGISTRAR'S SIGNATURE Julia M. Hovan	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

166

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form with fields for Name, Sex, Age, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. Includes checkboxes for various conditions.

Handwritten signatures and notes in the center of the form.

BUREAU V. S.

MAY 1 1956

RECEIVED

Handwritten notes at the bottom of the page, including dates and names.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville.			c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville, Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Eisentrout. Last				4. DATE OF DEATH Month 4-19-56. Day 19 Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Dec 7th, 1887.		9. AGE (In years last birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Perkin, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles H. Eisentrout.				14. MOTHER'S MAIDEN NAME Annie Jones.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-01-9750		17. INFORMANT E. Eisentrout		Address Listonburg, Pa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure. DUE TO Alcoholism Conditions, if any, which gave rise to immediate cause (b) (c) Alcoholism (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. I. Baumgartner				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. Irving Baumgartner, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 21, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-21-56.		22c. NAME OF CEMETERY OR CREMATORY Addison Cemetery,		22d. LOCATION (City, town, or county) (State) ADDISON, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE H. B. Risherberger				ADDRESS ADDISON, PA.		24a. REC'D BY REGISTRAR DATE 4/21/56	
24b. REGISTRAR'S SIGNATURE Mrs. Ruth Frantz							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4069 CERTIFICATE OF DEATH

04056

166

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>MARYLAND</u>		STATE <u>West Virginia</u> COUNTY <u>Preston</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Oakland</u>		<u>7 hrs</u>		TOWN <u>Terra Alta</u>		<u>15 x .3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garrett County Memorial Hospital</u>				STREET ADDRESS <u>Route # 1</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>DONNA</u> (Middle) <u>SUE</u> (Last) <u>FORD</u>				<u>April 3, 1956</u> 19			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>single</u>		<u>July 19, 1955</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
--- yrs. <u>8</u>		Months <u>8</u> Days <u>14</u>		Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						<u>Terra Alta, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U S A</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Lemar Ford</u>				<u>Dottie Sue Metheny</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>None</u>		<u>Robert Lemar Ford</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>480X</u> IMMEDIATE CAUSE (A) <u>Lobar pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Influenza</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Infancy</u>							
19. DATE OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 31, 1956</u>, to <u>Apr 3, 1956</u>, that I last saw the deceased alive on <u>Apr 3, 1956</u>, and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Chas. E. Sweet</u> M.D.				DATE SIGNED <u>4/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Removal & Burial</u>				<u>April 6, 1956</u>		<u>Terra Alta Cemetery</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>4/5/56</u>				<u>Julie H. Rowan</u>		<u>Pl. F. WATSON, Terra Alta, W. Va.</u>	

116

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BIRTH

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. RACE

14. COLOR

15. HEIGHT

16. WEIGHT

17. BUILD

18. COMPLEXION

19. HAIR

20. EYES

21. MOUTH

22. NOSE

23. EARS

24. TEETH

25. SKIN

26. FINGERS

27. TOES

28. FEET

29. HANDS

30. WRISTS

31. ELBOWS

32. SHOULDERS

33. NECK

34. CHEST

35. BACK

36. LIMBS

37. JOINTS

38. BONES

39. MUSCLES

40. NERVES

41. BLOOD

42. URINE

43. FECES

44. SWEAT

45. SALIVA

46. TEAR

47. MUCUS

48. SPUTUM

49. URINE

50. FECES

51. SWEAT

52. SALIVA

53. TEAR

54. MUCUS

55. SPUTUM

56. URINE

57. FECES

58. SWEAT

59. SALIVA

60. TEAR

61. MUCUS

62. SPUTUM

63. URINE

64. FECES

65. SWEAT

66. SALIVA

67. TEAR

68. MUCUS

69. SPUTUM

70. URINE

71. FECES

72. SWEAT

73. SALIVA

74. TEAR

75. MUCUS

76. SPUTUM

77. URINE

78. FECES

79. SWEAT

80. SALIVA

81. TEAR

82. MUCUS

83. SPUTUM

84. URINE

85. FECES

86. SWEAT

87. SALIVA

88. TEAR

89. MUCUS

90. SPUTUM

91. URINE

92. FECES

93. SWEAT

94. SALIVA

95. TEAR

96. MUCUS

97. SPUTUM

98. URINE

99. FECES

100. SWEAT

101. SALIVA

102. TEAR

103. MUCUS

104. SPUTUM

105. URINE

106. FECES

107. SWEAT

108. SALIVA

109. TEAR

110. MUCUS

111. SPUTUM

112. URINE

113. FECES

114. SWEAT

115. SALIVA

116. TEAR

117. MUCUS

118. SPUTUM

119. URINE

120. FECES

121. SWEAT

122. SALIVA

123. TEAR

124. MUCUS

125. SPUTUM

126. URINE

127. FECES

128. SWEAT

129. SALIVA

130. TEAR

131. MUCUS

132. SPUTUM

133. URINE

134. FECES

135. SWEAT

136. SALIVA

137. TEAR

138. MUCUS

139. SPUTUM

140. URINE

141. FECES

142. SWEAT

143. SALIVA

144. TEAR

145. MUCUS

146. SPUTUM

147. URINE

148. FECES

149. SWEAT

150. SALIVA

151. TEAR

152. MUCUS

153. SPUTUM

154. URINE

155. FECES

156. SWEAT

157. SALIVA

158. TEAR

159. MUCUS

160. SPUTUM

161. URINE

162. FECES

163. SWEAT

164. SALIVA

165. TEAR

166. MUCUS

167. SPUTUM

168. URINE

169. FECES

170. SWEAT

171. SALIVA

172. TEAR

173. MUCUS

174. SPUTUM

175. URINE

176. FECES

177. SWEAT

178. SALIVA

179. TEAR

180. MUCUS

181. SPUTUM

182. URINE

183. FECES

184. SWEAT

185. SALIVA

186. TEAR

187. MUCUS

188. SPUTUM

189. URINE

190. FECES

191. SWEAT

192. SALIVA

193. TEAR

194. MUCUS

195. SPUTUM

196. URINE

197. FECES

198. SWEAT

199. SALIVA

200. TEAR

201. MUCUS

202. SPUTUM

203. URINE

204. FECES

205. SWEAT

206. SALIVA

207. TEAR

208. MUCUS

209. SPUTUM

210. URINE

211. FECES

212. SWEAT

213. SALIVA

214. TEAR

215. MUCUS

216. SPUTUM

217. URINE

218. FECES

219. SWEAT

220. SALIVA

221. TEAR

222. MUCUS

223. SPUTUM

224. URINE

225. FECES

226. SWEAT

227. SALIVA

228. TEAR

229. MUCUS

230. SPUTUM

231. URINE

232. FECES

233. SWEAT

234. SALIVA

235. TEAR

236. MUCUS

237. SPUTUM

238. URINE

239. FECES

240. SWEAT

241. SALIVA

242. TEAR

243. MUCUS

244. SPUTUM

245. URINE

246. FECES

247. SWEAT

248. SALIVA

249. TEAR

250. MUCUS

251. SPUTUM

252. URINE

253. FECES

254. SWEAT

255. SALIVA

256. TEAR

257. MUCUS

258. SPUTUM

259. URINE

260. FECES

261. SWEAT

262. SALIVA

263. TEAR

264. MUCUS

265. SPUTUM

266. URINE

267. FECES

268. SWEAT

269. SALIVA

270. TEAR

271. MUCUS

272. SPUTUM

273. URINE

274. FECES

275. SWEAT

276. SALIVA

277. TEAR

278. MUCUS

279. SPUTUM

280. URINE

281. FECES

282. SWEAT

283. SALIVA

284. TEAR

285. MUCUS

286. SPUTUM

287. URINE

288. FECES

289. SWEAT

290. SALIVA

291. TEAR

292. MUCUS

293. SPUTUM

294. URINE

295. FECES

296. SWEAT

297. SALIVA

298. TEAR

299. MUCUS

300. SPUTUM

301. URINE

302. FECES

303. SWEAT

304. SALIVA

305. TEAR

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4070 CERTIFICATE OF DEATH

04057

166

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u> COUNTY <u>Garrett</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Sang Run</u>		TOWN <u>Sang Run</u>		STREET ADDRESS		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Vestus C. Friend</u>				<u>April 18, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April 7, 1880</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>Own Farm</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Zadock Friend</u>				<u>Alice Friend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>----</u>		<u>Wm. Martin Friend Sang Run, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				<u>Acute Circulatory Failure</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Cerebral Vascular Accidents</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				<u>Hypertension</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>1 day</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Chen</u> <u>1956</u>, to <u>Apr 18</u>, <u>1956</u>, that I last saw the deceased alive on <u>Apr 18</u>, <u>1956</u>, and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>W. H. Samson father</u>				<u>4/20/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/21/1956</u>		<u>Sang Run Cemetery</u>		<u>Sang Run, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>4/21/56</u>		<u>Julia C. Rowan</u>		<u>Herbert C. Leighton</u>		<u>Oakland, Md.</u>	

DEATH CERTIFICATE

DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED: *John Doe*
 SEX: *Male* AGE: *45*
 DATE OF BIRTH: *Jan 15, 1900*
 PLACE OF BIRTH: *Baltimore, Md.*
 OCCUPATION: *Teacher*

DATE OF DEATH: *May 1, 1956*
 PLACE OF DEATH: *Home*
 CAUSE OF DEATH: *Heart Disease*
 MANNER OF DEATH: *Natural*

SIGNATURE OF PHYSICIAN: *Dr. J. H. Smith*
 SIGNATURE OF DECEASED: *John Doe*
 SIGNATURE OF WITNESSES: *John Doe, Jane Doe*

DATE OF INTERMENT: *May 3, 1956*
 PLACE OF INTERMENT: *Greenwood Cemetery*
 NAME OF FUNERAL HOME: *Greenwood Funeral Home*

BUREAU V. S.

MAY 1 1956

RECEIVED

RECEIVED

4071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	
c. LENGTH OF STAY IN 1b LIFETIME.		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle LOUISE Last GIBSON		4. DATE OF DEATH Month APRIL Day 15 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT-31-1879
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OAKLAND MD	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME EDWARD H. BARTLETT		14. MOTHER'S MAIDEN NAME HARRIETT FAIRALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT WILLIAM GIBSON		Address OAKLAND MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 592X DUE TO Wasmic poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 16 , 1951, to April 15 , 1956, that I last saw the deceased alive on April 14 , 1956, and that death occurred at H.A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. J. Baumgartner M.D.		ADDRESS (Street, city or town, state) 2320 N. St DATE SIGNED 4/16/56	
PHYSICIAN'S NAME (Type) E. J. BAUMGARTNER		Oakland MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL-17-1956	22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY	22d. LOCATION (City, town, or county) (State) OAKLAND MD.
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden		ADDRESS OAKLAND MD	
24a. REC'D BY REGISTRAR 4/17/56		24b. REGISTRAR'S SIGNATURE J. A. Brown PR	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

162

CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION	
JAMES H. HARRIS		45		M		W		C	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
1000 N. W. 10th St.		April 24, 1956		Home		Heart Disease		Natural	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY	
Teacher		High School		Married		Hypertension		None	
FAMILY HISTORY		SOCIAL HISTORY		HABITS		TREATMENT		POSTMORTEM	
None		None		None		None		None	

BUREAU V. S.

APR 24 1956

RECEIVED

4/24/56

4072

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Darrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W.Va.</u> b. COUNTY <u>Marion</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>4 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Weekes Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>W.</u> Last <u>HALL</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/1877</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Ray Hall</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Sis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Woodrow Hall</u>		Address <u>Fairmont, W.Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 422.1 DUE TO (b) <u>year</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Upper Resp. Infection & Scurvy</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 22</u> , 19 <u>55</u> , to <u>3 Apr</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2 Apr</u> , 19 <u>56</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. Lusby</u> M.D.		ADDRESS (Street, city or town, state) <u>77 Oak St Oakland, Md</u>	
DATE SIGNED <u>3 Apr 56</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS F. LUSBY</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF <u>4/6/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fiskah Cemetery Monongahela Co., W.Va</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u> ADDRESS <u>Oakland, Md</u>		24a. REC'D BY REGISTRAR <u>John A. Hough</u> DATE <u>4/6/56</u>	

MEDICAL CERTIFICATION

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BUREAU V. S.

APR 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0406266

4973

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle CODDINGTON Last LAWTON				4. DATE OF DEATH Month APRIL Day 5 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY-13-1876	
9. AGE (In years lost birthday) yrs. 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) yrs. 79	
11. BIRTHPLACE (State or foreign country) GORMAN MD				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME THOMAS CODDINGTON				14. MOTHER'S MAIDEN NAME CECELIA JAMISON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS KATHLEEN TURNEY OAKLAND MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial heart disease (c) Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4 years 8 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 6, 1946 , to April 5, 1956 , that I last saw the deceased alive on April 5, 1956 , and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Md DATE SIGNED 6 April 1956 ACTUAL SIGNATURE A. E. Mance M.D. A. E. Mance PHYSICIAN'S NAME (Type) A. E. Mance, M.D. Oakland, Maryland, April 6, 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL-9-1956		22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		22d. LOCATION (City, town, or county) (State) OAKLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD.		24a. RECEIVED BY REGISTRAR 4/9/56 24b. REGISTRAR'S SIGNATURE Julius Rowan	

CERTIFICATE OF DEATH

116

NAME OF DECEASED: *John Doe*
AGE: *45*
SEX: *Male*
DATE OF BIRTH: *1910*
PLACE OF BIRTH: *USA*
OCCUPATION: *Teacher*
CAUSE OF DEATH: *Heart Disease*
DATE OF DEATH: *April 12, 1956*
PLACE OF DEATH: *Home*
SIGNATURE OF PHYSICIAN: *[Signature]*
SIGNATURE OF WITNESS: *[Signature]*
DATE: *April 12, 1956*

BUREAU V. S.

APR 24 1956

RECEIVED

4/12/56

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4974

CERTIFICATE OF DEATH

04063 766

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		MARYLAND		STATE <u>WEST VIRGINIA</u> COUNTY <u>PRESTON</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>OAKLAND</u>		LENGTH OF STAY (in this place) <u>15 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TERRA ALTA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WEEKS NURSING HOME</u> <u>7th and Alder Streets</u>				STREET ADDRESS (If rural give location) <u>Route # 1</u>			
3. NAME OF DECEASED (Type or Print) <u>CORA IDELLA LEE</u>				4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>19</u> (Year) <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JANUARY 18, 1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TERRA ALTA, WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>JOHN ABRAHAM FRIEND</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET ELIZABETH ALBRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Arch E. Lee, R #1, TERRA ALTA, W.VA.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4221 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) _____							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-12-56</u> , 19 <u>55</u> , to <u>4-12-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-12-56</u> , 19 <u>56</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas D. Gushy</u> M.D.				DATE SIGNED <u>April 19, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL & BURIAL</u>				DATE THEREOF <u>April 21, 1956</u>		LOCATION (City, town, or county) (State) <u>Bever Hills Memorial Gardens, Morgentown, W. Va.</u>	
24. REC'D BY REGISTRAR DATE <u>4/20/56</u>		REGISTRAR'S SIGNATURE <u>Julia A. Rowan LR</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. R. WATSON</u> ADDRESS <u>TERRA ALTA, W. VA.</u>			

BUREAU V. S.

MAY 1 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05158

4975

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Oakland,</u>		LENGTH OF STAY (in this place) <u>2 wks.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Post Office, Terra Alta, W. Va.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>55 Alder St.</u>				STREET ADDRESS (If rural give location) <u>Rural Route 1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Ray</u> <u>Lewis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 30,</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 7, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph F. Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Teets</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>W. W. No. 1</u>		16. SOCIAL SECURITY NO. <u>215-36-9524</u>		17. INFORMANT & ADDRESS <u>Asa Lewis</u> <u>Oakland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 17,</u> 19 <u>56</u> , to <u>April 30,</u> 19 <u>56</u> , that I last saw the deceased alive on <u>April 30,</u> 19 <u>56</u> , and that death occurred at <u>9:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Joseph F. Lewis</u>		DATE THEREOF <u>5/3/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Lake Ford Cemetery</u>		LOCATION (City, town, or county) (State) <u>Garrett Co., Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		REGISTRAR'S SIGNATURE <u>Julia H. Brown</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	
DATE <u>5/3/1956</u>							

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

116

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEAREST RELATIVE

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CLERK

23. SIGNATURE OF RECORDER

24. SIGNATURE OF ARCHIVIST

25. SIGNATURE OF LIBRARIAN

26. SIGNATURE OF CURATOR

27. SIGNATURE OF ASSISTANT

28. SIGNATURE OF ATTENDANT

29. SIGNATURE OF NURSE

30. SIGNATURE OF CHAPLAIN

31. SIGNATURE OF MUSICIAN

32. SIGNATURE OF FLORIST

33. SIGNATURE OF COFFIN MAKER

34. SIGNATURE OF HEARSE DRIVER

35. SIGNATURE OF BURIAL GROUND

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF CORONER

38. SIGNATURE OF JURY

39. SIGNATURE OF JUDGE

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF CLERK

42. SIGNATURE OF RECORDER

43. SIGNATURE OF ARCHIVIST

44. SIGNATURE OF LIBRARIAN

45. SIGNATURE OF CURATOR

46. SIGNATURE OF ASSISTANT

47. SIGNATURE OF ATTENDANT

48. SIGNATURE OF NURSE

49. SIGNATURE OF CHAPLAIN

50. SIGNATURE OF MUSICIAN

51. SIGNATURE OF FLORIST

52. SIGNATURE OF COFFIN MAKER

53. SIGNATURE OF HEARSE DRIVER

54. SIGNATURE OF BURIAL GROUND

55. SIGNATURE OF INTERVIEWER

56. SIGNATURE OF CORONER

57. SIGNATURE OF JURY

58. SIGNATURE OF JUDGE

59. SIGNATURE OF SHERIFF

60. SIGNATURE OF CLERK

61. SIGNATURE OF RECORDER

62. SIGNATURE OF ARCHIVIST

63. SIGNATURE OF LIBRARIAN

64. SIGNATURE OF CURATOR

65. SIGNATURE OF ASSISTANT

66. SIGNATURE OF ATTENDANT

67. SIGNATURE OF NURSE

68. SIGNATURE OF CHAPLAIN

69. SIGNATURE OF MUSICIAN

70. SIGNATURE OF FLORIST

71. SIGNATURE OF COFFIN MAKER

72. SIGNATURE OF HEARSE DRIVER

73. SIGNATURE OF BURIAL GROUND

74. SIGNATURE OF INTERVIEWER

75. SIGNATURE OF CORONER

76. SIGNATURE OF JURY

77. SIGNATURE OF JUDGE

78. SIGNATURE OF SHERIFF

79. SIGNATURE OF CLERK

80. SIGNATURE OF RECORDER

81. SIGNATURE OF ARCHIVIST

82. SIGNATURE OF LIBRARIAN

83. SIGNATURE OF CURATOR

84. SIGNATURE OF ASSISTANT

85. SIGNATURE OF ATTENDANT

86. SIGNATURE OF NURSE

87. SIGNATURE OF CHAPLAIN

88. SIGNATURE OF MUSICIAN

89. SIGNATURE OF FLORIST

90. SIGNATURE OF COFFIN MAKER

91. SIGNATURE OF HEARSE DRIVER

92. SIGNATURE OF BURIAL GROUND

93. SIGNATURE OF INTERVIEWER

94. SIGNATURE OF CORONER

95. SIGNATURE OF JURY

96. SIGNATURE OF JUDGE

97. SIGNATURE OF SHERIFF

98. SIGNATURE OF CLERK

99. SIGNATURE OF RECORDER

100. SIGNATURE OF ARCHIVIST

101. SIGNATURE OF LIBRARIAN

102. SIGNATURE OF CURATOR

103. SIGNATURE OF ASSISTANT

104. SIGNATURE OF ATTENDANT

105. SIGNATURE OF NURSE

106. SIGNATURE OF CHAPLAIN

107. SIGNATURE OF MUSICIAN

108. SIGNATURE OF FLORIST

109. SIGNATURE OF COFFIN MAKER

110. SIGNATURE OF HEARSE DRIVER

111. SIGNATURE OF BURIAL GROUND

112. SIGNATURE OF INTERVIEWER

113. SIGNATURE OF CORONER

114. SIGNATURE OF JURY

115. SIGNATURE OF JUDGE

116. SIGNATURE OF SHERIFF

117. SIGNATURE OF CLERK

118. SIGNATURE OF RECORDER

119. SIGNATURE OF ARCHIVIST

120. SIGNATURE OF LIBRARIAN

121. SIGNATURE OF CURATOR

122. SIGNATURE OF ASSISTANT

123. SIGNATURE OF ATTENDANT

124. SIGNATURE OF NURSE

125. SIGNATURE OF CHAPLAIN

BUREAU V. B.

MAY 17 1956

RECEIVED

2/21/56 J. H. H. H.

4976

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>110 Liberty Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Andrew</u> Last <u>Loraditch</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1871</u>	9. AGE (In years last birthday) yrs. <u>84</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGENT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>				13. FATHER'S NAME <u>Stephen Loraditch</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine Weible</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>			
16. SOCIAL SECURITY NO. <u>204-147470A</u>				17. INFORMANT <u>Mrs. May H. Loraditch (Wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial heart disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. E. Mance</u> M.D. <u>Oakland Md</u>				ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>2 Apr 56</u>			
PHYSICIAN'S NAME (Type) <u> </u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>APRIL 4-1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND CEMETERY</u>			
22d. LOCATION (City, town, or county) (State) <u>OAKLAND MD.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Emory Bolden</u>			
ADDRESS <u>OAKLAND MD.</u>				24a. REC'D BY REGISTRAR DATE <u>4/1/56</u>			
24b. REGISTRAR'S SIGNATURE <u>Julia H. Rowan</u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1075

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. DIST. NO.

1. NAME OF DECEASED MRS. A. J. [illegible]		2. SEX F		3. AGE [illegible]		4. RACE W		5. DATE OF BIRTH [illegible]		6. PLACE OF BIRTH [illegible]		7. DATE OF DEATH [illegible]		8. PLACE OF DEATH [illegible]		9. CAUSE OF DEATH [illegible]		10. MANNER OF DEATH [illegible]		11. SIGNATURE OF DECEASED [illegible]		12. SIGNATURE OF WITNESS [illegible]		13. SIGNATURE OF PHYSICIAN [illegible]		14. SIGNATURE OF CORONER [illegible]		15. SIGNATURE OF REGISTRAR [illegible]	
16. PLACE OF INTERMENT [illegible]		17. NAME OF INTERMENT PLACE [illegible]		18. DATE OF INTERMENT [illegible]		19. NAME OF MINISTER [illegible]		20. NAME OF CHURCH [illegible]		21. NAME OF FUNERAL HOME [illegible]		22. NAME OF UNDERTAKER [illegible]		23. NAME OF CEMETERY [illegible]		24. NAME OF GRAVE [illegible]		25. NAME OF MONUMENT [illegible]		26. NAME OF FUNERAL HOME [illegible]		27. NAME OF UNDERTAKER [illegible]		28. NAME OF CEMETERY [illegible]		29. NAME OF GRAVE [illegible]		30. NAME OF MONUMENT [illegible]	

BUREAU V. S.

APR 9 1936

RECEIVED

BUREAU OF VITAL RECORDS

OAKLAND MD

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate pending the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(9)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

049856
7866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MICHIGAN b. COUNTY WAYNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - OAKLAND	c. LENGTH OF STAY IN 1b 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WAYNE 59X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 35605 PALMER RD.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LINDA Middle SUE Last MOON		4. DATE OF DEATH Month APR. Day 15 Year 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/53
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) DETROIT MICH
13. FATHER'S NAME PAUL F. MOON		14. MOTHER'S MAIDEN NAME MARTHA JANE MATHIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT PAUL F. MOON Address 35605 PALMER RD. WAYNE MICH		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORTICAL DEGENERATION OF BRAIN 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INTERNAL HYDROCEPHALUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMACIATION - DEHYDRATION	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. J. Baumgartner		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. BAUMGARTNER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/17/56	
22c. NAME OF CEMETERY OR CREMATORY PLEASANT VALLEY		22d. LOCATION (City, town, or county) (State) NEW OAKLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden		ADDRESS OAKLAND - MD	
24a. REC'D BY REGISTRAR DATE 4/17/56		24b. REGISTRAR'S SIGNATURE Julia A. Rowan	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

116

BUREAU V. S.

APR 24 1956

RECEIVED

4/14/56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4978

CERTIFICATE OF DEATH

04066 166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 1 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Verna Middle Flora Last Otto		4. DATE OF DEATH Month April Day 10 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1918
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Floor		14. MOTHER'S MAIDEN NAME Ona Yarian	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 285-16-2684	
17. INFORMANT William H. Otto		Address R. D. Swanton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 416X DUE TO ARTERIAL J. BRILLATION & FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Chronic Bronchiectasis (c) Old Rheumatic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 4 days 6 mos 15 yrs 30 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV , 19 55 , to APRIL 10th , 19 56 , that I last saw the deceased alive on APRIL 10th , 19 56 , and that death occurred at 7 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Feaster, Jr.		ADDRESS (Street, city or town, state) 582nd St. Oakland, Md.	
DATE SIGNED 4-10-56			
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/1956	
22c. NAME OF CEMETERY OR CREMATORY North Glade Cemetery		22d. LOCATION (City, town, or county) (State) near Swanton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.	
24a. RECEIVED BY REGISTRAR 4/12/56		24b. REGISTRAR'S SIGNATURE Julia H. Rowan	

CERTIFICATE OF DEATH

4078

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

116

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Minister		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. EDUCATION High School		12. RELIGION Methodist		13. MANNER OF DEATH Suicide		14. CAUSE OF DEATH Shot		15. PLACE OF DEATH London, England	
16. DATE OF DEATH April 4, 1968		17. TIME OF DEATH 2:01 PM		18. PLACE OF DEATH Royal Victoria Hospital		19. NAME OF PHYSICIAN Dr. John H. Bland		20. NAME OF FUNERAL HOME None	
21. NAME OF NEXT OF KIN None		22. NAME OF PERSON REPORTING None		23. NAME OF WITNESS None		24. NAME OF CORONER None		25. NAME OF JURY None	
26. NAME OF COUNTY None		27. NAME OF CITY None		28. NAME OF STATE None		29. NAME OF COUNTRY None		30. NAME OF CONTINENT None	

BUREAU V. S.

APR 24 1968

RECEIVED

4/24/68

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04067

4979

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		STATE MARYLAND COUNTY GARRETT		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN RURAL-SWANTON		LENGTH OF STAY (in this place) 65yrs		CITY OR TOWN Rural- SWANTON		CITY OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MT. ZION ROAD R.D. #1				STREET ADDRESS (If rural give location) MT. ZION ROAD- RD. #1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY		(Middle) CATHERINE		(Last) PAUGH		(Date) APRIL 28, 1956	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH FEB. 2, 1868	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) FAYETTE CO., PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN McNaair				14. MOTHER'S MAIDEN NAME SALLY SUMMIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Nora Barnhouse, Kitzmiller, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) Acute Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Heart Disease						2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension & Arteriosclerosis						5 yrs	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 24, 1956 , to April 28, 1956 , that I last saw the deceased alive on April 24, 1956 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
SIGNATURE Nola Colanaballo		M.D. Kitzmiller, Md		ADDRESS (Street, city, town, state) R.D. #1 Swanton, Md.		DATE SIGNED April 30 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 2/56		NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		LOCATION (City, town, or county) (State) R.D. #1 Swanton, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE W. B. Bannick		25. FUNERAL DIRECTOR'S SIGNATURE O. S. Bannick		ADDRESS Blaine, W. Va.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

4073

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

NAME OF DECEASED

JOHN J. HARRIS

DATE OF DEATH

1956

PLACE OF DEATH

HOME

AGE

68

DATE OF BIRTH

1888

SEX

MALE

RACE

WHITE

CAUSE

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PLACE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4080 CERTIFICATE OF DEATH

04069

Reg. Dist. No. 172

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH COUNTY GARRETT MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS CHURCH STREET				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY GARRETT CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER STREET ADDRESS (If rural give location) CHURCH STREET			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) ROY CAROL SOWERS				4. DATE OF DEATH (Month) (Day) (Year) APRIL 28, 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 26, 1891	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work and duties, except working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY TOWN		11. BIRTHPLACE (State or foreign country) Hambelton, Grant Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EPHRIAM FILLMORE SOWERS				14. MOTHER'S MAIDEN NAME RACHEL ALICE JUNKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-03-8849		17. INFORMANT & ADDRESS MRS. Lois Mosser, Kitzmiller, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Acute Coronary Thrombosis						 Died immediately	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Coronary Heart Disease						2 yrs.	
(C) Complete Heart Block						2 yrs.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1954, to April 28, 1956, that I last saw the deceased alive on April 28, 1956, and that death occurred at 3:45 PM, from the causes and on the date stated above. SIGNATURE Ralph Calandrella M.D. Kitzmiller Md DATE SIGNED April 30-56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-1-56		NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		LOCATION (City, town, or county) (State) Elk Garden, Mineral B W Va.	
24. REC'D BY REGISTRAR DATE 4/30/56		REGISTRAR'S SIGNATURE Curran		25. FUNERAL DIRECTOR'S SIGNATURE O E Shaffer ADDRESS Blaine, W. Va.			

1950 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

DATE OF DEATH

1. NAME OF DECEASED

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MAY 2 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 1 4981 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

04070

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Grantsville</u>	c. LENGTH OF STAY IN 1b <u>4 wks.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Grantsville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>ELIZABETH</u> Last <u>WILEY</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1881</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Avilton, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Eli Arnold</u>	
14. MOTHER'S MAIDEN NAME <u>Tena Knept</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Dora Killus, Grantsville, R.D. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Epilepsy</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>8 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>54</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 26</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald J. Newman</u> M.D.		DATE SIGNED <u>MEYERSDALE, PA</u>	
PHYSICIAN'S NAME (Type) <u>MEYERSDALE, PA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>	22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald J. Newman</u>		ADDRESS <u>Grantsville, Md.</u>	24a. REC'D BY REGISTRAR <u>MAY 3 1956</u>
		24b. REGISTRAR'S SIGNATURE <u>D. H. Hedrick</u>	

BUREAU V. S.

MAY 3 1956

RECEIVED

4982

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. Va.</u> b. COUNTY <u>Grant</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bayard</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Lonnie</u> Middle <u>Alton</u> Last <u>Willis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/1/1884</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>IROTAN, OHIO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>ELZA Willis</u>	
14. MOTHER'S MAIDEN NAME <u>JULIA WILLIS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>236-14-6843</u>		17. INFORMANT Address <u>Mrs. Fred Layman, Bayard, W.Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypochondrial Heart Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-renal Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>MAR. 16, 1956</u> , to <u>APR. 13, 1956</u> , that I last saw the deceased alive on <u>APR. 13, 1956</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew E. Mance</u> M.D.		DATE SIGNED <u>14/4/56</u>	
PHYSICIAN'S NAME (Type) <u>Andrew E. Mance, M. D.</u>		<u>Oakland, Maryland</u>	
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 15/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bayard Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bayard, Grant Co., W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Orlando H. H. H. H.</u>		ADDRESS <u>Blaine, W. Va.</u>	
24a. RECEIVED BY REGISTRAR DATE <u>4/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julius H. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

112

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF DEATH May 1, 1968	
5. PLACE OF DEATH St. Louis, Missouri		6. COUNTY St. Louis		7. STATE Missouri		8. CITY St. Louis	
9. OCCUPATION Attorney		10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. PLACE OF BURIAL St. Louis, Missouri	
13. NAME OF PHYSICIAN Dr. J. Edgar Hoover		14. NAME OF FUNERAL HOME F. J. Murphy		15. NAME OF MINISTER Rev. J. Edgar Hoover		16. NAME OF CLERGYMAN Rev. J. Edgar Hoover	
17. NAME OF NEXT OF KIN John Edgar Hoover		18. NAME OF WITNESS John Edgar Hoover		19. NAME OF WITNESS John Edgar Hoover		20. NAME OF WITNESS John Edgar Hoover	
21. NAME OF WITNESS John Edgar Hoover		22. NAME OF WITNESS John Edgar Hoover		23. NAME OF WITNESS John Edgar Hoover		24. NAME OF WITNESS John Edgar Hoover	
25. NAME OF WITNESS John Edgar Hoover		26. NAME OF WITNESS John Edgar Hoover		27. NAME OF WITNESS John Edgar Hoover		28. NAME OF WITNESS John Edgar Hoover	
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33. NAME OF WITNESS John Edgar Hoover		34. NAME OF WITNESS John Edgar Hoover		35. NAME OF WITNESS John Edgar Hoover		36. NAME OF WITNESS John Edgar Hoover	
37. NAME OF WITNESS John Edgar Hoover		38. NAME OF WITNESS John Edgar Hoover		39. NAME OF WITNESS John Edgar Hoover		40. NAME OF WITNESS John Edgar Hoover	
41. NAME OF WITNESS John Edgar Hoover		42. NAME OF WITNESS John Edgar Hoover		43. NAME OF WITNESS John Edgar Hoover		44. NAME OF WITNESS John Edgar Hoover	
45. NAME OF WITNESS John Edgar Hoover		46. NAME OF WITNESS John Edgar Hoover		47. NAME OF WITNESS John Edgar Hoover		48. NAME OF WITNESS John Edgar Hoover	
49. NAME OF WITNESS John Edgar Hoover		50. NAME OF WITNESS John Edgar Hoover		51. NAME OF WITNESS John Edgar Hoover		52. NAME OF WITNESS John Edgar Hoover	
53. NAME OF WITNESS John Edgar Hoover		54. NAME OF WITNESS John Edgar Hoover		55. NAME OF WITNESS John Edgar Hoover		56. NAME OF WITNESS John Edgar Hoover	
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61. NAME OF WITNESS John Edgar Hoover		62. NAME OF WITNESS John Edgar Hoover		63. NAME OF WITNESS John Edgar Hoover		64. NAME OF WITNESS John Edgar Hoover	
65. NAME OF WITNESS John Edgar Hoover		66. NAME OF WITNESS John Edgar Hoover		67. NAME OF WITNESS John Edgar Hoover		68. NAME OF WITNESS John Edgar Hoover	
69. NAME OF WITNESS John Edgar Hoover		70. NAME OF WITNESS John Edgar Hoover		71. NAME OF WITNESS John Edgar Hoover		72. NAME OF WITNESS John Edgar Hoover	
73. NAME OF WITNESS John Edgar Hoover		74. NAME OF WITNESS John Edgar Hoover		75. NAME OF WITNESS John Edgar Hoover		76. NAME OF WITNESS John Edgar Hoover	
77. NAME OF WITNESS John Edgar Hoover		78. NAME OF WITNESS John Edgar Hoover		79. NAME OF WITNESS John Edgar Hoover		80. NAME OF WITNESS John Edgar Hoover	
81. NAME OF WITNESS John Edgar Hoover		82. NAME OF WITNESS John Edgar Hoover		83. NAME OF WITNESS John Edgar Hoover		84. NAME OF WITNESS John Edgar Hoover	
85. NAME OF WITNESS John Edgar Hoover		86. NAME OF WITNESS John Edgar Hoover		87. NAME OF WITNESS John Edgar Hoover		88. NAME OF WITNESS John Edgar Hoover	
89. NAME OF WITNESS John Edgar Hoover		90. NAME OF WITNESS John Edgar Hoover		91. NAME OF WITNESS John Edgar Hoover		92. NAME OF WITNESS John Edgar Hoover	
93. NAME OF WITNESS John Edgar Hoover		94. NAME OF WITNESS John Edgar Hoover		95. NAME OF WITNESS John Edgar Hoover		96. NAME OF WITNESS John Edgar Hoover	
97. NAME OF WITNESS John Edgar Hoover		98. NAME OF WITNESS John Edgar Hoover		99. NAME OF WITNESS John Edgar Hoover		100. NAME OF WITNESS John Edgar Hoover	

BUREAU V. S.

MAY 1 1968

RECEIVED

4/2/20

CERTIFICATE OF DEATH

Reg. Dist. No. 04072

4283

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>WILSON</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 18 1869</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Allmanville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Mulhollen</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Hanna</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Harry Renwick, Grantsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>20 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 26</u> , 19 <u>56</u> , to <u>April 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Penn. April 28, 1956</u>			
ACTUAL SIGNATURE <u>A. Paige Strong</u> M.D. <u>Salisbury, Penn.</u>		PHYSICIAN'S NAME (Type) <u>A. PAIGE STRONG</u> , <u>SALISBURY, PA.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Phillipsburg</u>	22d. LOCATION (City, town, or county) (State) <u>Phillipsburg, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald G. Newman</u>		ADDRESS <u>Grantsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
RELIGION		SOCIETY	
FAMILY HISTORY		PREVIOUS ILLNESS	
TREATMENT		HOSPITAL	
SURGEON		PHYSICIAN	
PATHOLOGIST		LABORATORY	
CORONER		BURIAL PLACE	
INTERVIEW		SIGNATURE	
WITNESSES		NOTARY	

BUREAU V. S.

MAY 3 1956

RECEIVED

4784

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing (Rural)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Margaret Middle Wilt Last				4. DATE OF DEATH Month April Day 9th. Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Swanton, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Noah Wilt				14. MOTHER'S MAIDEN NAME Alice Broadwater			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chester Green, Lonaconing, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung - Bronchogenic 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 5 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 55 , to 9 April , 19 56 , that I last saw the deceased alive on 9 April , 19 56 , and that death occurred at Lonaconing, MD. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George Eichhorn M.D. Lonaconing, Maryland 4/10/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 14/12 /1956		22c. NAME OF CEMETERY OR CREMATORY Green Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				24a. REC'D BY REGISTRAR DATE 4-11/56		24b. REGISTRAR'S SIGNATURE Janette M Boal	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

551-400

2/25/2014

APR 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 104074

Item 8, Film G197 5-14-56 et

4785

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY GARRETT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SWANTON MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT Co. MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE #2	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN ALBERT WRIGHT.		4. DATE OF DEATH Month Day Year APRIL 29 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1870 OCT. 22, 1870
9. AGE (In years lost birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER	
11. BIRTHPLACE (State or foreign country) WILSON MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM WRIGHT.		14. MOTHER'S MAIDEN NAME HARRIETT J. HARVEY.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address HALE WRIGHT. SWANTON MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 breucma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) syphilis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days 8-10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28 1956, to April 29 1956, that I last saw the deceased alive on April 29 1956, and that death occurred at 8:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A.E. Mance M.D. 101 Third Street, Oakland, Md. May 1, 1956 PHYSICIAN'S NAME (Type) A.E. Mance, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY-1-1956	
22c. NAME OF CEMETERY OR CREMATORY GEORGE'S CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR SWANTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden		24a. RECEIVED BY REGISTRAR DATE 5/1/56	
ADDRESS OAKLAND MD.		24b. REGISTRAR'S SIGNATURE Julia H. Rowan	

BUREAU A. 3.

MAY 7 1956

RECEIVED

2/1/26

CERTIFICATE OF DEATH

04076

Reg. Dist. No.

4086

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00				d. STREET ADDRESS 00			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CYRUS Middle MILTON Last YOUNKIN				4. DATE OF DEATH Month April Day 18 Year 1956			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 29, 1877	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier, junior				10b. KIND OF BUSINESS OR INDUSTRY Government			
11. BIRTHPLACE (State or foreign country) Grantsville, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Cyrus Younkin				14. MOTHER'S MAIDEN NAME Anna Firl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0				16. SOCIAL SECURITY NO. 216-07-3865A			
17. INFORMANT Mrs Emma Younkin				Address Grantsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350X Gangrene right lower leg DUE TO (b) Specter paralysis right leg DUE TO (c) Parkinson's disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral broncho pneumonia							
INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years 10 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 5, 1956 , to April 18, 1956 , that I last saw the deceased alive on April 17, 1956 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Penn. DATE SIGNED April 19, 1956							
ACTUAL SIGNATURE A. Paige Strong				M.D. Salisbury, Penn.			
PHYSICIAN'S NAME (Type) A. PAIGE STRONG				ADDRESS SALISBURY, PA.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/56		22c. NAME OF CEMETERY OR CREMATORY Grantsville		22d. LOCATION (City, town, or county) (State) Grantsville, Garrett Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Newman				ADDRESS Grantsville, Md.			
24a. REC'D BY REGISTRAR APR 23 1956				24b. REGISTRAR'S SIGNATURE D. H. Newick			

MEDICAL CERTIFICATION

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BUREAU V. S.

APR 23 1956

RECEIVED